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In the sixth and last lecture the bilateral connections of certain cortical centres—such as those for the trunk—are discussed. It would appear that there is never any recovery of function due to the assumption of new functions by other parts of the cortex, but that the apparent restitution depends ultimately on this bilateral connection. It would further appear that the associated movements of limbs on opposite sides of the body are due to similar anatomical connections. The complete separateness of the motor areas and those for the dermal senses is maintained on the ground of both experimental and clinical evidence. The motor character of the cortical motor centres and their dependence on the surrounding sensory centres is emphasized. Of the function of that portion of the hemispheres lying in front of the praecentral sulcus little can be said, save that it is connected with fibres in the anterior portion of the internal capsule which degenerate downwards on its removal; that it passes over into the centres for the movements of the head and eyes, and that when it is removed both men and animals show some impairment of intelligence.

*The So-called Motor Area of the Cortex.* EDWARD B. LANE, M. D. American Journal of Insanity. April, 1891.

The author examines some of the evidence for the motor character of certain regions of the cortex. In pursuing this he discusses the muscle sense, aphasia in its various forms, and the very interesting cases of "motor hallucinations" described by Tamburini and Séglas. In these cases the patient detected the words which are spoken to them, or better through them, or which they are forced to speak (!) not through an auditory sensation, but by means of the "movements of their own tongue," to employ their expression. In the case of Tamburini the tongue could be seen to move at the tip, but when held motionless (?) the hallucinations still occurred. Further, while the patient is pronouncing one group of words she feels at the same time others forming in her mouth. The author concludes strongly in favor of the sensory nature of the so-called motor cortex.

In criticism of this general view a little anatomy will assist us. (Supposing that motor cells, or those giving rise to efferent impulses, exist predominantly in the motor regions, they must be started into action by impulses from the periphery—i. e., sensory impulses. One question is then whether these sensory impulses reaching the motor cortex by sensory fibres there find sensory, or better central, cells with which they connect and by way of which they act on the motor cells, or whether the sensory fibres act directly on the motor cells. Histology does not enable us to decide the point, though pending a decision the latter view has been generally accepted. That the motor region contains a very large number of cells that carry efferent impulses from the cortex, we know from the make up of the internal capsule, and the pyramidal tracts, and the question here is, whether these peripherally discharging cells have some sensory function. This has been usually answered in the negative. We do not say that these usual views are correct, but think that the detailed anatomy of the cortex as well as the clinical facts should be admitted into so important a discussion. REV.)

*Hemianopsia.* HENRY D. NOYES. N. Y. Medical Record. April 4, 1891.

In considering hemianopsia as "a visual manifestation of intra-cranial disorder" a number of interesting points are clearly developed. The very large number of instances in which the dividing line in hemianopsia spares the fixation point is important. This occurs in most cases not only of the homonymous form, but also in those of double hemianopsia, as illustrated by some three cases. This immunity of central vision in

these cases cannot at present be adequately explained. Forster's suggestion of better blood supply to the cortical region corresponding to the fovea, is at present an hypothesis. In discussing the relation between the cortex and the retina Hun's case is quoted as significant. It must be remembered, however, that according to the experiments on animals the (ventral) lower portion of the cuneus is associated with the lower portion of the retina, while in Hun's case the lower portion of the cuneus is associated with the upper portion of the retina—an important difference. Sector defects in the field are more usually associated with disease of the cortex, while irregular defects are more likely to be subcortical.

As regards the perceptions of light, color and form it occurs, of course, that the loss of light perceptions necessarily involves the other two—but either of these alone—form or color may be lost independently. The two theories advanced to explain these are (1) separate areas for the two functions, lying beside one another, and (2) separate strata in the cortex lying above one another. It would be rash to say that either view was satisfactorily supported, but the latter seems to have rather the better support from the cases cited.

*History of a case of sarcoma of genu of the corpus callosum, presenting symptoms of profound hysteria: With autopsy.* CHARLES A. OLIVER, M. D. University Medical Magazine. Philadelphia, April, 1891.

The patient was a woman 43 years of age, who had suffered from severe mental strain associated with retroversion of the uterus. She exhibited symptoms shortly before her death which led to the diagnosis of profound hysteria, possibly combined with a gross intracranial lesion situated anteriorly and at the base of the brain.

The basis of this was the mutability of the ocular symptoms; the characteristic fields; the absence of any expressive motor changes; the condition of the fundus oculi, in association with the mental derangements; the loss of the senses of smell and taste; ovarian tenderness; abundant limpid urine without abnormal excreta; the absence of cephalgia, vomiting, vertigo, or any gross general symptoms of cerebral growth and a constant highly emotional condition.

In the left eye, vision was lost save in a small region to the nasal side of the visual field. Central vision for form for the right eye was but  $\frac{1}{10}$ th and could not be optically improved. The left pupil reacted only to the stimulation of the region mentioned. In the right eye a sluggish reaction of the pupil followed stimulation of either half of the retina. The field for color vision was very variable owing to the rapid fatigue due to the tests, the color first tested giving the largest field. The disturbance of vision was first noted by the patient, next smell and taste were lost by degrees and in the order named. Disturbance in hearing was not recognized, but upon testing, hearing was found deficient. Extreme lassitude was followed by her remaining continuously in bed. Visual illusion and hallucinations then appeared. The latter were of a very persistent sort, the former took the form of indefinite multiplication of special objects—all clearly projected. Tactile illusions followed and combined themselves with the visual ones. The muscle sense and that of pain and temperature appeared normal. There was no indications of any form of aphasia.

At the autopsy, the brain alone was examined. The tumor above mentioned was found attached to the genu. Its shape was hemispherical and its two greatest diameters six and five and one-half centimeters respectively. Its greatest bulk lay to the left of the median line. The uncinate gyri, the olfactory tubercles, the cephalic portion of the gyrus fornicatus and both optic nerves, but especially the left one, were the parts most affected.

The disturbances of vision are associated with the pressure on the optic nerves; those of taste and smell with that on the uncinate gyrus